

15

The Patient’s Personality, Personality Types, Traits, and Disorders

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15.1 Vignettes

1. A 34-year-old Caucasian woman was admitted to the hospital after cutting her abdomen with a steak knife. She had methodically cut her skin, abdominal muscles, fasciae, peritoneum, and omentum, and pulled out her small intestine. She was in a pool of blood when her roommate came home and called the ambulance. Upon admission to the hospital, the patient denied suicidal intent; rather, she said she just had to cut herself and see blood to relieve the tension. She had seen visions of herself cutting before she actually cut herself. She felt no pain. Her abdomen was covered with scars from previous lacerations. This was her 18th hospitalization for cutting herself.
2. A psychiatric consultation was requested on a patient who was admitted to the hospital with back pain. A spinal mass was discovered on imaging and further diagnostic workup was in progress. The patient seemed to the staff to be depressed, just staring at the ceiling, and not sleeping or eating. The patient was an accountant, and was concerned about his business while he was in the hospital. The consultant was impressed with the detailed, exacting description he gave of his symptoms and signs, as well as descriptions of his job and other concerns. When asked, the patient admitted that what made him most anxious was not knowing what was going on in the hospital, what each procedure was, and what the diagnosis and prognosis were. The consultant arranged a meeting among the patient, the resident responsible for the patient, and, at his request, the patient’s wife. During the meeting, the resident explained in detail the diagnostic and

therapeutic plans for the patient utilizing printouts of Web pages. The patient's seeming depression immediately lifted, and he began to cooperate with the treatment plans.

15.2 Concepts of Personality

Personality refers to the totality of attributes of a person including intelligence; cognitive, perceptual, and behavioral traits; and habitual coping styles. *Character*, in the psychodynamic sense, refers to an individual's typical ways of dealing with reality and stress determined by unconscious defense mechanisms such as denial and projection.

Personality is formed by the interaction of genetic predisposition with early environment and the accumulation of experiences and learning. For example, the short allele of the serotonin transporter promoter gene *5HTTLPR* may underlie an anxious trait that in interaction with experience may give rise to increased neuroticism and anxious or borderline personality traits (see Chapter 6). Monoamine oxidase A gene, in interaction with childhood abuse, has been implicated in the development of the antisocial personality disorder. The stress of medical illness and hospitalization often causes a regression in the patient's personality; that is, the patient retreats to a more immature, child-like state with an exaggeration of the personality traits. By understanding a patient's personality, the physician can then determine how it influences the patient's ways of perceiving the world. This understanding leads to an approach to the patient that would result in better a physician–patient relationship and increased patient cooperation.

Prominent aspects of personality may be classified loosely into types. The Myers-Briggs Personality Inventory, based on Carl Jung's work, is an example that is used commonly. This typology contains the following dimensions: Introversion (I)–Extraversion (E), Sensing (S)–Intuition (N), Thinking (T)–Feeling (F), and Judging (J)–Perceiving (P). Based on the predominance of these dimensions, a person's typology may be, for example, Introverted, Intuitive, Thinking, and Perceiving type (INTP). Eysenck's personality test measures three dimensions: *extroversion* as a measure of cortical activation (extroverts being underaroused, introverts being overaroused), *neuroticism* as a measure of activation thresholds of limbic or sympathetic system (minor stresses activate them in neurotics), and *psychoticism*, a tendency toward psychotic breaks and aggression (see Chapter 6 for a discussion of how personality traits may be predispositions for major psychiatric syndromes).

If everyone has a personality, and normal persons can be classified by personality type, what is a *personality disorder*? In our view, there is a continuum between normality and disorder. The only demarcation line is whether patients feel consistently distressed and their function is persistently impaired because of the personality characteristics. Borderline personality disorder patients are often severely distressed and nonfunctional, and they often suffer from comorbid major psychiatric syndromes such as major depression and substance use. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) classifies personality disorders in three clusters: cluster A, characterized by oddness and eccentricity, and includes the paranoid, schizoid, and schizotypal personality disorders; cluster B, characterized by

colorful, dramatic, emotional, or erratic behaviors, and includes the antisocial, borderline, histrionic, and narcissistic personality disorders; and cluster C, characterized by shy, anxious, and fearful behaviors, and includes the avoidant, dependent, and obsessive-compulsive personality disorders.

The consultation-liaison (CL) psychiatrist must understand the interaction of personality types with the sick role that patients must assume in the general hospital setting (Kahana and Bibring, 1964; Leigh and Reiser, 1992).

15.3 Personality Types, the Sick Role, and Management Strategies

We conceptualize a continuum of normal personalities with certain traits that may be characteristic of personality disorders when persistent and severe. Many normal patients who are hospitalized will show transient exaggerations of their personality traits as a result of the stress of illness, hospitalization, and treatment. This section describes the types of traits, their interaction with the sick role (for further discussion of the sick role, see Chapter 28), and management strategies based on the personality needs.

15.3.1 Cluster A: Odd and Eccentric Personalities

15.3.1.1 Seclusive, Aloof Patients (Schizoid Personality)

This is the type of patient who seems to be remote, detached, and not in need of interpersonal contact. These patients usually prefer to be in private rooms and seldom speak or relate to other patients or staff. They like to be involved in solitary activities, such as reading or listening to music. They appear shy and uninvolved. Nurses are sometimes so disturbed by the aloofness and lack of personal response that they suspect depression, and thus bring the patient to the attention of the physician. Some patients with this personality might also appear to be eccentric, with affinities for activities associated with countercultures, such as unusual foods and quasi-religious sects.

The main concern of these patients is a desire not to be intruded on by others; they wish to maintain a sense of tranquility by being absorbed in themselves and things familiar to them. Any attempt at socialization by others may be seen as an intrusion threatening their fragile tranquility.

Illness is seen as a threat to this self-absorption and tranquility. These patients, therefore, have difficulty in adjusting to the sick role, with its expectation of dependency on and cooperation with health care personnel. The patients come to terms with the role expectations through noninvolvement at a personal level while allowing the medical process to go on. Thus, a patient with this personality may appear to be strikingly unconcerned about illnesses and procedures that would normally be expected to arouse much anxiety. Of course, many patients with this personality delay seeking help because of their aversion to the intrusion into their privacy that is necessary in receiving medical care. On the other hand, some patients with this personality may use the sick role as an excuse to develop interpersonal relationships but without true intimacy.

In managing such patients, it is important to recognize and respect their need for privacy. Although socialization and sharing are important to most people, these patients need to protect their privacy and tranquility. Some of these

patients, however, may be able to form some relationship with one or two members of the hospital staff. These staff members can then serve as “translators” for these aloof patients.

15.3.1.2 Odd, Eccentric Patients with Schizophrenia-Like Tendencies (Schizotypal Personality)

These are patients who seem odd and eccentric, have limited interpersonal contact, and have unusual experiences such as derealization and depersonalization, and they may manifest magical thinking, odd beliefs, paranoia, and other tendencies that approximate schizophrenia. Such patients may have peculiar beliefs and perceptions concerning illness that may conflict with the views of the medical profession. Health care professionals may be alarmed or turned off by the odd and eccentric behavior of such patients. Sick role expectations are often not shared by such patients. Managing patients who are odd and eccentric requires an understanding that the attributes are of long standing, and that the patient cannot really help being odd. Accepting and respecting such patients' individuality will allow a reduction of anxiety and perhaps paranoia so that medical treatment can be optimal. If the patient has a psychosis-like experience, perhaps precipitated by the stress of hospitalization and medical illness, small doses of antipsychotic medication may be helpful, for example, olanzapine 5 mg hs, risperidone 0.5 mg hs, b.i.d. po., or perphenazine 2 mg hs or b.i.d.

15.3.1.3 Guarded, Suspicious Patients (Paranoid Personality)

Patients with this personality type are always watchful and concerned about the possibility that harm might be done to them, intentionally or unintentionally. They are quite fearful of being exploited or taken advantage of. They are quite sensitive to the possibility of criticism. They are prone to wonder about ulterior motives concerning any suggestions or remarks made by the health-care personnel, especially if they are ambiguous. These patients are also likely to misinterpret statements and actions and read something ominous or threatening into them. This is especially true in the presence of great anxiety, as in being hospitalized, and in states of reduced cerebral function that impair the integration of sensory input.

Such patients also tend to blame others for their illness. For example, a patient may claim that he developed a heart attack because his employer did not provide air conditioning for his work area and “poisoned the air” with carbon dioxide exhaled by so many others.

These patients, obviously, do not enjoy being in the sick role. The dependency on health care personnel increases their feelings of vulnerability, and with that comes the fear that persons in powerful positions will do harm to them or take advantage of them. Although they see the ill state as an undesirable one, they cannot trust the physician enough to cooperate fully.

A good management strategy for these patients is to assume a relatively neutral attitude concerning their suspicions, criticisms, and other manifestations of hostility without becoming provoked by them or arguing with them. A helpful statement is, “I understand how you feel under the circumstances.” Identifying their suspiciousness as “sensitivity” is also helpful. Occasionally, agreeing with the patients about the inconveniences that they are suspicious about and then putting the blame on impersonal things like hospital regulations can diffuse their feelings of anger from being directed toward the health care personnel.

Above all, it is important to provide as little cause for suspicion as possible. This involves consistency on the part of health care personnel in terms of the

information imparted to the patient. It is also necessary to explain, in as much detail as feasible, the nature of the patient's illness and plans for treatment. This will tend not only to minimize the suspiciousness but also to reduce the likelihood of litigation in case of complications, since this type of patient is likely to be litigious as well. When a procedure is recommended to the patient, it is best to present it as objectively as possible, so as not to arouse the suspicion that the doctor is trying to "manipulate" the patient for ulterior motives.

In severe cases, small doses of antipsychotic medications may help to reduce the degree of suspiciousness and accompanying anxiety during the hospitalization, for example, olanzapine 5 mg hs or risperidone 0.5 mg hs or b.i.d. po.

15.3.2 Cluster B: Colorful, Dramatic, Emotional, or Erratic Personalities

15.3.2.1 Dramatizing, Emotional Patients (Histrionic Personality)

Patients with this personality type tend to come across as being rather charming and fun to talk with. They have a certain dramatic flair when giving accounts of their lives and are often quite amusing. Their histories tend to be more impressionistic and diffuse than precise. They may be overtly seductive: female patients wearing provocative negligees and "parading around" in the hospital; male patients making sexually seductive comments to nurses and female physicians. There is a tendency for these patients to consider their relationship with the doctor as special, with sexual overtones. The medical staff often finds itself split around these patients, some liking them very much and others feeling angry with them. The patients themselves have usually unwittingly provoked these split reactions.

A major concern underlying such behavior is the need to be attractive and desirable to others, to prove their masculinity or femininity over and over again and to gain care and support. An underlying fear that they might not be found attractive and desirable is accentuated by illness, with its threat to the integrity of the body. As patients, persons of this type have an exaggerated need to be reassured that they are still attractive and will not be deserted.

The sick role may or may not be compatible with this type of personality. On the one hand, the dependency and social perquisites inherent in the sick role afford some of these patients an acceptable opportunity to exhibit and "flirt" with authority figures in a situation that sets limits. Patients with extreme forms of this personality, despite their overtly sexually provocative behavior, tend to be rather inhibited in actual sexual encounters. For them, the hospital and medical treatment may be exactly the type of setting they find most comfortable for seductive behavior without danger of actual sexual activity. On the other hand, some patients become extremely frustrated by the confinement and limitations of the sick role, especially if they had been accustomed to active, exhibitionistic, and gratifying lifestyles. For example, a man who had been accustomed to a "Don Juan" lifestyle may find the restriction of sexual activity in the hospital most unbearable.

These patients do best when the doctor responds amiably and engages them within set boundaries and limits. However, this should not be overdone, since these patients also tend to be frightened if their characterological seductiveness seems to lead to unexpected intimacy. Showing some warmth and personal concern is usually all that is needed. When there seems to be a split in staff feelings, these should be openly discussed and resolved in staff meetings. It may also be necessary to set firm limits with these patients, at the same time indicating

concern and willingness to continue to take care of them. Repeated reassurances are often necessary. With this group of patients, unlike the orderly, controlling personalities, the doctor's personal manner and attitudes are relatively more important in providing reassurance than factual content, such as discussion of objective findings and test results.

15.3.2.2 Patients with Intense, Unstable Relationships (Borderline Personality, Emotionally Unstable Personality)

These patients have a pattern of unstable and intense interpersonal relationships, unstable self-image, and marked impulsivity that are self-damaging, such as substance abuse, compulsive sexual activity, and binge eating. They often suffer from chronic feelings of emptiness, and may have transient stress-related dissociative symptoms. These patients arouse very strong feelings among the hospital staff members, because such patients tend to see them as either all good or all bad (splitting). Consequently, some staff members feel very positively about these patients while others feel exactly the opposite. Such patients regress easily, and may act out impulsively if they feel uncared for. Their demands for care, affection, and, often, special treatment may escalate if they feel that the staff is accommodating. The basic difficulty with these patients is that almost all relationships become stormy, such that the doctor who was "perfect" one day may become a persecuting monster the next day because of a perceived mistreatment or imperfection.

In more severe cases, the patients are diagnosed as having the borderline personality disorder, which often also includes the features of suicide attempts, unstable sense of self, negative affect (anger, bitterness, demandingness, sadness), brief psychotic experiences, impulsivity, and low achievement (Gunderson, 1984). They often engage in substance abuse and demonstrate eating disorders. Borderline personality disorder requires psychotherapy combined with pharmacotherapy for depression, anxiety, or psychosis if present (Gunderson, 1984; Koerner and Linehan, 2000; Meissner, 1988). Borderline personality disorder patients often engage in cutting behaviors for tension relief rather than with suicidal intent (as in vignette 1 at the beginning of the chapter). Dialectical behavior therapy (DBT) has been especially designed for borderline personality disorder and has shown good results (Koerner and Linehan, 2000).

Patients who attempted suicide (which may be the reason for psychiatric consultation) or demonstrated serious suicidal ideation may require psychiatric hospitalization. In the general medical setting, the approach should be caring but, above all, consistent, with explicit expectations on the part of both the patient and the staff. The caregiver must recognize that these patients invariably produce intense feelings as a part of their personality makeup, but that he or she must provide a consistent, evenhanded, and caring approach to them.

15.3.2.3 Impulsive Patients with a Tendency to Act Out (Impulsive Personality—Not a DSM-IV Diagnosis)

These are the patients who keep on doing things they did not "mean" to do, usually on the basis of some impulse. These patients may appear to be rational and well controlled, until an impulsive action occurs. Usually, however, they have a history of being involved in interpersonal or legal difficulties because of some maladaptive acting-out behavior. The characteristic feature is a lack of deliberation, with decisions being reached on the spur of the moment. Patients with this character style seem to lack tolerance for sustained thinking and for frustration.

They often say that they acted “without thinking” or “could not help” what they did and often are quite remorseful afterward. In the health care system, these impulsive actions usually involve some aggressive acts against health care personnel or ill-advised decisions such as signing out against medical advice despite having a serious illness.

These patients seem to feel an overwhelming sense of impotence in the presence of relatively minor frustrations and appear to be unable to delay gratification or to feel gratified by anticipatory cognitive processes such as planning.

Patients with an impulsive personality style are likely to seek help for relatively minor symptoms based on the immediate pain or discomfort experienced, and they are likely to demand immediate relief from the discomfort. If immediate relief is not produced, they are prone to acting out by such aggressive acts as cursing at the physician or kicking an article of equipment in the treatment room. Such patients, although wanting immediate relief from symptoms, often have difficulty in tolerating the treatment process, especially when it also involves some discomfort, such as swallowing a gastric tube. Although these patients may appear to have understood the necessity of such a procedure, they are as likely to curse and attempt to sign out in the midst of the procedure when discomfort occurs. Thus, cooperation with the physician (a sick-role expectation) is difficult for these patients.

Medical professionals, trained to be always deliberate and objective, tend to dislike patients with this personality type. They see these patients as being defective and childish. In fact, this style may be a manifestation of a defect in the integrative functions of the brain rather than a primarily developmental personality style. In fact, it is well known that brain-damaged patients frequently exhibit impulsive behavior. It is important, therefore, for health care personnel to deal with it as a defect, just as they have to recognize and deal with a diabetic patient's metabolic defect. The management strategy, thus, would involve preventing situations in which the defect would be of major consequence and compensating for it when it is unavoidable.

For example, tranquilizers may be utilized more freely for these patients as a partial preventive measure against outbursts of aggression. Benzodiazepines such as lorazepam 1 to 2 mg may be used 30 minutes before a procedure. First-generation antipsychotics (e.g., perphenazine 2 to 4 mg b.i.d.) may be used for their neuroleptic effect so as to decrease the patient's stimulus-bound immediate response to discomfort. Second-generation antipsychotics (e.g., risperidone, olanzapine, aripiprazole) and mood stabilizers (e.g., valproic acid) may also be considered.

Pain should be treated especially vigorously. Firm limit-setting is also necessary to establish some external control over these patients' acting-out behavior. In fact, these patients feel reassured by firm limit-setting, which also gives them a sense of external control and caring. Whenever possible, persons familiar to the patient, such as friends and relatives, should be mobilized to support and control the patient.

15.3.2.4 Superior and Special Patients (Narcissistic Personality)

These are patients who behave like VIPs, whether or not they are. Such patients have a tendency to appear snobbish, self-confident, and sometimes grandiose. They are often quite proud of their bodies and their physical abilities. This basic style might be partially covered up by exaggerated, artificial humility. There is a

sense of arrogance and disdain when they are in contact with other people. Though these patients may seek the most prestigious medical centers and the most eminent physicians when ill, there is often an air of tentativeness in their responses when the physician explains anything to them. They may display an arrogant attitude, especially toward persons on the lower strata of the hospital hierarchy, such as house officers, student clerks, and nurse's aides. They are likely to threaten to notify the chief of service or the director of the hospital of any inconveniences they suffer. They also use "name-dropping" to try to impress health care personnel.

Many patients with this personality style have idealized body images, and illness represents a threat to the maintenance of this body image. Many neurotic patients with overvaluation of physical prowess, stamina, and fitness were found to have developed the neurosis after illness or injury, often of a minor nature (the "athlete's neurosis"; Little, 1969).

The patients with superiority feelings naturally do not find the sick role agreeable. Their need to see themselves as being perfect and invulnerable is contradictory to the notion that they "cannot help themselves" and are in need of more competent help. Although they may submit to this unpleasant situation, they often attempt to find weaknesses and faults in the physicians, as though to cut them down to size in order to still feel superior to them.

Needless to say, health care personnel often resent this type of attitude. The result is often a battle between the caregiving staff and the patient, each attempting to cut the other down!

Successful management of these patients involves a certain degree of magnanimity on the part of health care personnel, allowing these patients to boast of their strengths. When this is done, the patients may feel secure enough to identify the caring persons with the self as being almost perfect. It is, however, a mistake to be unnecessarily humble in relation to these patients. An attitude of security about one's professional competence, while recognizing the worth of the patient, is important to ward off insecure feelings on the patients' part that they might not be in the best hands after all.

15.3.2.5 Patients with Repeated Legal Difficulties and Behavioral Problems (Antisocial Personality)

These patients have a pattern of failure to conform to social norms, resulting in arrest, repeated lying, and deceiving others for profit or pleasure. They are often impulsive and aggressive, resulting in repeated fights. They tend to show personal and financial irresponsibility and to lack remorse, showing indifference to others' feelings. There is a history of conduct difficulty before the age of 15, and these patients are unable to learn from experience, especially from punishment. It is therefore unrealistic to expect such patients to adhere without difficulty to the sick role expectations. These patients are often unreliable, demanding, uncooperative, impulsive, and aggressive. Managing such patients requires a firm and nonjudgmental attitude and explicit explanations as to how cooperation can result in specific benefit for the patient. Unreasonable demands should be declined based on explicit reasons or rules. Breach of rules and unlawful activity, if present, should be reported to the appropriate authorities. It is important for the health care personnel to realize that such patients naturally evoke angry feelings in others but that such provocations are part of their personality deficit.

15.3.2.6 Patients with Mood Swings (*Cyclothymia*)

These patients characteristically have “ups and downs,” that is, periods of relative euphoria and hyperactivity followed by periods of depressed feelings and lack of energy. Although most people have some periods characterized by euphoric or depressive moods, persons who have this personality trait exhibit such mood swings consistently. During the “up” periods, they feel optimistic, ambitious, and usually physically well. During the “down” periods, feelings of pessimism and a sense of malaise predominate. If these changes are exaggerated so as to cause major problems in function, the psychiatric diagnosis of bipolar illness should be considered (see Chapter 9).

The importance of recognizing this personality trait lies in that, depending on the mood in which these patients find themselves, the reaction to illness and to the medical treatment may vary. When an illness occurs during an up period, patients may not even recognize the presence of the symptoms, or even if the patients do recognize them, they may brush them aside as being of no consequence. If patients happen to be in a down phase, however, they may feel quite pessimistic about the symptoms and attach all kinds of grave implications to them. In fact, they may be convinced, even before they see a physician, that they have a terminal illness for which there is no hope. In addition, because of the feelings of malaise and lack of energy experienced during the down phase, these patients may experience exaggerated discomfort that may be caused by minor dysfunctions.

Patients with this personality trait might be more prone to developing severe depression in the presence of major stress such as a serious medical illness. If a patient who has this pattern develops evidence of serious depression, including feelings of hopelessness, guilt, and lowered self-esteem, coupled with weight loss, anorexia, sleep disturbances, and, perhaps, suicidal thoughts, referral to a psychiatrist should be made for definitive treatment. This is also true for any other patients who show similar evidence of depression.

15.3.3 Cluster C: Shy, Anxious, and Fearful Personalities

15.3.3.1 Dependent, Demanding Patients (*Dependent Personality*)

It is said that one can detect this type of personality by noting the amount of luggage the patient brings to the hospital. An exaggerated caricature form of this personality is indeed seen in the patients who come into the hospital as though they were prepared to stay for months, if not years. Patients of this type have a need for a great deal of reassurance and often want special attention from health care personnel. They tend to become dependent on the doctor and others who are involved in their care and often make frequent, inappropriately urgent calls to nurses and doctors. When their (excessive) demands are not met fully, they tend to feel angry and rejected.

The underlying dynamic for this type of personality is considered to be a regressive wish to be cared for as though by an idealized, nurturant mother. The fear of being rejected, left out in the cold, and neglected tends to exaggerate the need for reassurance and care. The sick role may be considered to be a temptation for these patients to return to a state of infantile dependency, and they may consider the illness to be a result of a lack of protection and concern by others.

The incessant demands of a patient of this type, coupled with relative comfort in the dependent position, may be regarded by others, especially doctors and nurses, as “enjoying” being sick, counter to the sick role expectation that the

patient should consider being ill an undesirable state and try to get better by seeking and cooperating with medical care.

When excessive demands for attention are not met, the patient may become hostile, in turn provoking anger and conflict. The nurses, for example, may feel that the patient wants too much attention, while the patient feels that the nurses are cold and uncaring.

There is a flip side to this coin as well. A patient of this type was referred to the psychiatrist by an alarmed surgeon because he too eagerly consented to an amputation the first time it was discussed as a possibility. In this instance, it was learned that the doctor had been overly indulgent with the patient, allowing special privileges and giving an inordinate amount of care and attention. The patient, before long, regarded the doctor as an omnipotent, mothering figure and wanted to go along with anything that the doctor suggested might be good for him.

15.3.3.2 Orderly, Controlling Patients (*Obsessive-Compulsive Personality*)

Such patients tend not to show feelings and generally experience illness without outward signals of emotional reaction. Their descriptions of symptoms are complete, precise, and dispassionate.

This personality style is motivated by a desire to control external as well as internal states. Behind the desire to control may be fear of loss of control or being helpless.

The sick role is obviously difficult for patients with these personality characteristics. Removal from normal responsibilities and daily routine may be experienced as disruptive. Being unable or not permitted to help themselves may be an alien experience for them. Needing to seek advice and help from a professional may generate concerns about who will control whom, and they may feel deeply threatened by the control that doctors and nurses must assume over their lives and their bodies in order to administer the necessary medical care.

In response to these threats, they may become contentious, complaining, and accusatory. Usually quite conscious of time and details, such as medication schedules, they may become incensed and critical if the nurse brings a pill a few minutes late.

Such patients do not respond favorably to blanket reassurances. They are likely to wonder if the physician is competent when reassurances are given without firm foundation in facts. The doctor's explanation of one hopeful laboratory finding may be far more reassuring to this type of patient than many impressionistic but unsupported optimistic statements.

A rule of thumb in dealing with this type of personality is to attempt to recruit the patient to be a part of a therapeutic team effort against the illness. This enables patients to feel that the physician respects their autonomy enough to ask them to cooperate in the common endeavor. Detailed explanations of the diagnosis, the physical and laboratory findings, and treatment plans are helpful, especially for more educated patients (as in vignette 2 above). Sometimes it is useful to the patients to help the treatment team by keeping a diary of symptoms or by recording some of their clinical data, such as the volume of water drunk and urine voided.

15.3.3.2.1 Case History: A chemistry technician with diabetes mellitus was admitted for treatment of leg ulcers. Within days after admission, he complained of the "sloppiness" of the doctors and nurses, and their lack of punctuality in bringing his medications. Successful management involved the physician's

acknowledging the patient as someone related to the medical profession. (“As a chemist, you would understand the mechanism of diabetes mellitus. Now, we want to treat this with diet and insulin, and we will follow the course with blood glucose levels.”) In addition to giving the patient credit for his knowledge of chemistry, the doctor taught him to change his own medicated dressings (he could do it “much better than any nurse”) and to keep track of his medications to be sure that they were taken on time.

15.3.3.3 Long-Suffering, Self-Sacrificing Patients (Masochistic Personality Trait)

Some experienced physicians say that this personality type can be diagnosed by the pitch and tone of the patient’s first utterance in the doctor’s office. Such patients often speak in a wailing, complaining voice, and usually the history involves a long list of hard luck and disasters: surgical operations followed by complications, trusted persons turning out to be untrustworthy, promised cures for a symptom bringing on more symptoms and side effects than relief, and other complaints. They almost always have endured protracted pain and suffering, and this “present illness” represents an additional suffering for a patient who seems to have been “born to suffer.”

When listening to patients with this type of personality, one usually finds that they have taken care of someone else despite their own suffering and misery. They take much pride in relating how this feat was achieved in the presence of so much suffering and so many misfortunes. Often, that someone else is a child, a spouse, or a parent.

A major underlying dynamic in these patients is considered to involve strong feelings of guilt that do not allow them to enjoy life for themselves. With a “need” to suffer in order to expiate the guilt feelings, altruistic activities (such as caring for others) in the presence of physical or emotional pain may allow them some covert gratification (claim to happiness). Thus, these patients appear as though they are “exhibiting” their misfortunes, sufferings, and altruistic acts.

Another underlying dynamic in such patients is the use of pain and suffering as a lifestyle, as a means of maintaining interpersonal relationships. These are patients who might be “addicted” to the sick role (see Chapter 13). The sick role is taken on from time to time throughout their lifetimes, although they also feel proud of having taken care of others despite the sick-role restrictions. A closer scrutiny reveals that the sick role is assumed as a way of meeting their needs indirectly through suffering and through ongoing contact with the physician. Many patients diagnosed as “hypochondriacs” have this personality type (see Chapter 14).

Patients with this type of personality often become severe problems for health care personnel. Typically, they tend to *react negatively to reassurances*, totally frustrating the doctors. When the physician prescribes a medication and offers the reassurance that it will relieve the pain, these patients are likely to return complaining of more rather than less pain, which may now be felt in areas that were previously free of pain! In addition, they may have nausea and dizziness. They may even overtly blame the physician for their added troubles, but most often this is attributed to bad luck. The physician, nevertheless, is often made to feel guilty by these patients. This frequently results in a rejection of the patient by the physician, which adds to the patient’s feeling of being mistreated. Thus, these patients commonly have a history of repeated rejection or transfer from doctor to doctor.

If not quite reaching the degree of pathology in factitious disorder (Munchausen syndrome), the long-suffering personalities are often addicted to the sick role, and thus appear to the health care personnel not to consider being sick an undesirable state and pay only lip service to wanting to get well.

Patients with this personality type are best managed when the physician gives “*credit*” to their suffering and expresses appreciation for their courage and perseverance in the face of protracted pain and hardship. It is a mistake to promise such patients complete relief from pain and suffering. In fact, since they need to expiate guilt and maintain relationships, such a promise may provide a powerful reason for the patients’ “refusal to improve.” Taking away the symptoms and suffering would leave them exposed and helpless, without any means of relating to others.

Recognition of this pattern also helps the physician to recognize the necessity to accept and set limited goals for the treatment in order to avoid later frustration, feelings of helplessness, and reactive anger. This can prevent or postpone the development of disruptive tension in the relationship with the patient. It is often helpful for the physician to approach this type of patient with some degree of pessimism, such as, “Although we cannot take away the pain completely, this medication may take the edge off the pain somewhat.”

Attempts to mobilize altruistic tendencies may also be helpful. For example, a patient may be persuaded to seek proper treatment to alleviate crippling pain so that she might be better able to care for her children.

One has to differentiate this type of personality from patients who experience protracted suffering due to actual complications from treatment. Patients suffering from chronic illnesses without this character style do not show the self-sacrificing element, and although they may feel rather cynical about the prolonged illness, they do not show the tendency to “refuse to improve.”

15.3.3.4 *Shy, Anxious, Rejection-Sensitive Patients (Avoidant Personality)*

These patients do not reach out to people for fear of rejection—that they are not likable, socially inept, and likely to be criticized. Thus, they tend to avoid activities that are likely to involve interpersonal contact. Hospitalization would be especially stressful for these patients because of the necessity to deal with new sets of people, both health care professionals and other patients, who might all dislike them, criticize them, and reject them. Managing such patients involves understanding their fear of criticism and rejection. A good approach to these patients entails a friendly and caring attitude and patiently explaining the procedures and treatments, as these patients are very much in need of feeling accepted by others.

15.4 From Types to Individuals

As should be clear from our discussion, the various characteristics of personality types are not mutually exclusive but tend to coexist in varying combinations. One of our most gratifying experiences is to hear our students complain to us, after a discussion of personality types, that they could not actually categorize a single patient neatly into any single type. The personality types described here are like caricatures. In real life, it is the rule rather than the exception to see patients with characteristics belonging to several personality types. For example, one patient may be orderly and controlling *and* guarded and suspicious, or

another may be dependent and demanding *and* also have mood swings. Once an individual is recognized as being unique, with certain characteristics from several different personality types, then the management of such a patient can be truly individualized.

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